

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

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1400 E. Washington Avenue
Madison, WI 53703

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Website: <http://www.drl.state.wi.us>

MEDICAL EDUCATION VERIFICATION FORM

MEDICAL EXAMINING BOARD

(Not necessary if utilizing FCVS)

IMPORTANT: PLEASE FORWARD THIS FORM TO YOUR MEDICAL SCHOOL

The State of Wisconsin requests that you complete this form concerning the following individual:

APPLICANT'S NAME: _____ Soc. Sec. #* _____

MEDICAL SCHOOL: _____

MEDICAL SCHOOL ADDRESS: _____

- | | <u>YES</u> | <u>NO</u> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Did this physician attend the medical school noted above? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What were the applicant's dates of enrollment in this medical school? _____ | | |
| 3. Did this physician graduate from this medical school?
If no, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| Degree Granted _____
Date Degree Granted _____ | | |
| 4. Did this individual take a leave of absence during his/her attendance at this medical school?
If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did this individual have a record of unexcused absences during his/her attendance at this medical school? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Was this individual ever disciplined or under investigation during his/her attendance at this medical school? If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Were any special requirements imposed on this individual that were not required of all other students at his/her level of education? If yes, please attach explanation on a separate sheet. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Was this individual recommended for post-graduate training? | <input type="checkbox"/> | <input type="checkbox"/> |

Print name of Dean _____

Signature of Dean _____

Date form was completed _____

*For use in school locating your records

SEAL OF
MEDICAL SCHOOL

Please return directly to:

Department of Regulation and Licensing
Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935